infant. Respiration is established more slowly in the child after this procedure, but ultimately the child will breathe well. The same thing may be done in Cesarean section at the moment when the uterus is incised and the child delivered. So also patients who have received morphin before operation will benefit by pure oxygen. Cases of eclampsia are also benefited by this method. In forceps cases the operator must be careful not to begin traction with the forceps before the patient is completely relaxed. If the effort to extract the child is begun too soon no aid is secured from the uterus.

While the reviewer has had an experience similar to that of Danforth in many respects, he has also been led to believe that in highly toxic patients gas is a very dangerous remedy. In these patients the action of the heart is greatly disturbed and the second sound may be largely lessened or even abolished. Gas is sometimes rapidly fatal to such a patient. The safest anesthetic for use in all the requirements of obstetric practice is ether and oxygen. If these are combined by an experienced anesthetist the reviewer has seen no emergency in obstetric practice which could not safely be met by such anesthesia skilfully given.

GYNECOLOGY

UNDER THE CHARGE OF

JOHN G. CLARK, M.D.,

PROFESSOR OF GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA,

AND

FRANK B. BLOCK, M.D.,

INSTRUCTOR IN GYNECOLOGY, MEDICAL SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA.

Radiotherapy of Fibroids.—Until within the most recent past the treatment of fibroids has been exclusively surgical and the results achieved have been eminently satisfactory. Every decade has seen a material reduction in the mortality after operations for fibroids, but even in the hands of excellent surgeons there is yet an average mortality of from 3 to 5 per cent, and if we consider all the cases operated upon we would probably find a considerably higher percentage. Contrast with this the fact that radiotherapy has a mortality of zero. To be sure the word "cure" means something different in the two methods, according to GELLHORN (*Jour. Missouri State Med. Assn.*, 1921, xviii, 220), who calls attention to the fact that we obtain a cure after operation if we remove the fibroid and the patient survives and is well thereafter. In radiotherapy, on the other hand, we aim at only a *clinical* cure, that is to say, the object to be accomplished is attained, if the menorrhagia caused by the fibroid either ceases altogether or only a scanty or infrequent menstrual flow ensues. Furthermore a reduction in the size of the tumor is a part, though not an essential one, of the clinical cure after radiotherapy. With these definitions in mind we

must approach the statistics thus far published. Many thousands of cases of fibroids have already been treated with radium or the roentgen rays, and the results obtained show on the whole a marked similarity. In order not to quote too many figures, the author mentions the collective statistics of 2982 cases of fibroids treated with the roentgen rays, in which there were 95.6 per cent cures and 4.4 per cent failures. In 944 fibroids treated with radium there were 94.4 per cent cures and 5.6 per cent failures. These statistics take into consideration the results obtained in various parts of the world, and they include the cases in which the technic had to be first acquired as well as those in which the technic had attained its present state of refinement. If only the latter kind were tabulated, Gauss and Friedrich found that in 425 fibroids roentgen-ray treatment yielded 98.4 per cent cures and had only 1.6 per cent failures, and exactly the same result was obtained in 372 fibroids treated with radium. It is important to remember that this type of treatment must not be given to fibroids which extend above the umbilicus. Large pedunculated subserous or submucous fibroids are likewise unsuited. In these three categories radiotherapy may produce a necrosis of the tumors. Cervical fibroids are refractory to radioactive treatment. Rapidly growing fibroids suggestive of sarcomatous degeneration, suppurating or gangrenous fibroids, or those in which any other form of degeneration has taken place, are to be operated upon, likewise those associated with carcinoma of the uterus. Fibroids pressing heavily upon the bladder or rectum had better be removed surgically. It is important, therefore, to carefully select the cases which are to be radiated, since the man who administers radiotherapy indiscriminately disregards the best interests of his patients as much as the man who adheres exclusively to surgery.

Observations on Ectopic Gestation.—Any series of 307 cases of ectopic pregnancy must be of interest to the gynecologist but when, in addition to its size, such a series occurs in the practice of and is analyzed by such a surgeon as Polak (*Am. Jour. Obst. and Gynec.*, 1921, ii, 280), it must of necessity contain much of practical importance. His experience has shown that clinically all ectopics fall into two general classes: (1) Those which may be classed as in the non-tragic stage, with a pulse distinctly countable of 100 or under with a systolic pressure of 100 or over and a hemoglobin of 60 per cent or more. In this class there were 263 cases. (2) And those in the tragic stage pulseless at the wirst, with a blood pressure below 90, a hemoglobin under 50 and definite signs of internal hemorrhage and collapse. In this class there were 36 cases. The analysis of this series shows that ectopic pregnancy occurs most frequently where there is a congenital anomaly or a previous inflammation of the tube, in the woman who gives a history of premenstrual dysmenorrhea. Like other pregnancies, there is a period of amenorrhea or an attempt at menstrual suppression, but because of the unstable position of the ovum owing to the imperfectly developed tubal decidua and erosion of the ovum into the underlying muscle and venous radicles, bleeding takes place into the decidua and produces such ovular unrest as to cause tubal distention and peristalsis which is evidenced by colicky pains and uterine bleeding. The bleeding into the decidua plus the growing ovum distends the tube and causes the soreness and tenderness